Millman Derr Patient Health Summary Sheet

Date: ____________________ Pt #:___________

Patient Name: ____ Date of Birth: _____________________

Primary Family Drs name and address: ____

____Fax#:_________________________

List of Allergies (Medications, Latex, Rubber, Food): ____

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Health History (SELF):

EYE:	Yes	No
Glaucoma	___	___
Retinal Detachment	___	___
Lazy Eye	___	___
Macular Degeneration	___	___
Dry Eye	___	___

Previous Surgeries were….Please write the year & the doctors Name.

None: ___

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GENERAL HEALTH:	Yes	No
Smoker	___	___
Asthma	___	___
Emphysema	___	___
TB	___	___
High Cholesterol	___	___
High Blood Pressure	___	___
Angina	___	___
Heart Attack	___	___
Irregular Heart Rate	___	___
Pacemaker	___	___
Internal Cardiac Defibrillator		
Any Implanted Electronic Device List: ____________________	___	___
Arthritis: Rheumatoid or Osteo	___	___
Rosacea	___	___

	Yes	No
Problem with falling?	___	___
Head Injury	___	___
Migraine Headaches Type: _______________	___	___
TIA/Stroke (Date) _______	___	___
Muscle Weakness/Disease List: _______________	___	___
Diabetes: Date Diagnosed: _______	___	___
Thyroid Problems	___	___
Bleeding/Clotting Problems	___	___
HIV/AIDS	___	___
Lupus	___	___
Sarcoid	___	___
Cancer/Location______________	___	___
Date Diagnosed: ______________		

Current Oral Medications= Eye Drops (how often), Others (INCLUDE MG), prescription and non-prescription/Herbal type, Patches etc. None: ____

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Family History:

	Who	Yes	No
Diabetes	________	___	___
Glaucoma	________	___	___
Macular Degeneration	________	___	___
Retinal Detachment	________	___	___

Pharmacy Name: ____________________________

Address: ________________________________

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Phone # ________________________________